Chapter 2

Overview

Significant changes in health care delivery over the past decade have created the need to revitalize and reorganize VA health care infrastructure to better serve our nation's veterans. As one of the largest integrated health care delivery systems in the world, VA faces complex institutional and cultural challenges to keep pace with the demands associated with delivering care to veterans. These challenges drive the CARES process, which is the most comprehensive review of VA health care infrastructure ever conducted. As such, it provides an unprecedented opportunity to enhance health care for veterans.

One particularly noteworthy change in VA health care over the last decade is the establishment of more than 700 community-based outpatient clinics (CBOCs) throughout the United States.[1] The CBOCs reflect VA's adoption of a community-based delivery model and its commitment to improving veterans' access to high quality health care in the communities where they live.

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Through this period of transition, VA maintained its leadership role and dedication to excellence in providing specialized services and groundbreaking research in such areas as treatment of spinal cord injury and rehabilitation for the blind. Overall, the number of veterans is projected to decline 16 percent by FY 2012, from approximately 25 million in FY 2002 to fewer than 21 million by FY 2012.[2] The number of veterans enrolled in VA health care is projected to increase from 6 million enrollees in FY 2001 to 6.3 million by FY 2012, and then to decrease to 5.7 million by FY 2022.[3]

[1] Veterans Service Support Center (VSSC) KLF Menu Database, *CBOC-VAST Report*, Fiscal Year 2003, as of November 16, 2003.
[2] *Veteran Health Care Enrollment and Expenditure Projections, FY 2002-2012 From the FY 2003 Baseline Care Demand Model*, Department of Veterans Affairs, Veterans Health Administration, Office of Policy and Planning (105), September 2002, page 3.
[3] *Veteran Health Care Enrollment and Expenditure Projections, FY 2002-2012 From the FY 2003 Baseline Care Demand Model*, Department of Veterans Affairs, Veterans Health Administration, Office of Policy and Planning (105), September 2002, page 3.

Drivers of Change

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Significant changes in health care delivery nationwide continue to shape VA's ongoing effort to provide quality health care services to veterans. One of the primary drivers of change has been a transition from an inpatient to an outpatient health care delivery model. The aging of the veteran population is another trend affecting the entire VA health care system. The number of veterans entering the later stages of life is driving changes in needed services and greater reliance on VA services. Changes in VA eligibility requirements in the last decade have opened the system to additional veterans, leading to an overall growth in enrollment. Additionally, consistent with national trends, VA has seen a significant migration of veterans into the Sunbelt of the United States.[4] Responding to these changes, as well as to concerns raised by veterans service organizations (VSOs), Congress, the General Accounting Office (GAO), and stakeholder organizations, is a significant challenge to VA.

VA infrastructure and support facilities, many built in the aftermath of World War II, are not all configured for contemporary health care delivery, and some are no longer appropriately located. Moreover, with an average age exceeding 50 years, these buildings are becoming more costly to maintain. The CARES process is intended to address these issues, strategically realigning capital assets to enhance the health care infrastructure to better meet veterans' health care needs over the next 20 years.

Barriers to Change

Although most stakeholders, VA leadership, and VISN personnel agree on the need for some changes in the system, the challenge begins with determining the necessary changes and weighing the impact of these changes at the local level. VA has built-in barriers to change rooted in its decentralized operating model and the organizational boundaries that comprise the VISN structure. The organization of the VISNs, each having independent budgets and goals, does not always promote inter-VISN referral processes, communication, or cooperation. Examples of this include the placement of new medical centers and CBOCs without the benefit of a regional perspective. In addition, certain proposals in the DNCP were developed on a national level, such as the placement of spinal cord injury and blind rehabilitation units. In developing these proposals, however, inter-VISN cooperation was not required or even recommended.

[4] Allen Berkowitz and Stephen Meskin, *The Veteran Population Forecasting Model*, Department of Veterans Affairs, Office of Policy and Planning, Office of the Actuary. September 14, 2000.

An additional barrier to change on the VISN level is the natural inclination toward preserving the status quo and the absence of real incentives for VISN leadership to change. Maintaining the status quo responds to stakeholder and community pressure to maintain a system, specific facilities, and methods of providing services that are familiar to veterans, staff, and others. This resistance to change is also based on fear of the unknown and of possibly losing services at VA facilities. Additionally, change can mean a loss of VA and community jobs or a shift in the configuration or location of VA staff.

VA facilities and campuses often have historical value. Some of these facilities and campuses have been providing services since shortly after the Civil War. Additionally, veterans in many areas are accustomed to facilities located on large campuses that have been preserved from development. This creates a peaceful venue for care delivery, and veterans and stakeholders frequently resist proposals that campuses be divested, leased, or developed, even though their preservation and upkeep is a costly and inefficient use of resources that could be better directed toward health care delivery.

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Finally, certain areas, such as those with large and growing veteran populations, become the natural beneficiaries of DNCP proposals for increased services and resources. Other areas with a diminishing veteran population may see resources shifted to areas with greater demand. This creates a significant challenge, one that must be overcome to ensure the necessary configuration of resources to continue to provide quality health care to veterans. Therefore, the Commission urges stakeholders and elected officials when reviewing the proposed realignment of resources to evaluate the CARES process from the national perspective of how to best serve our nation's veterans.

CARES Process and Model

The CARES Process

VA divided the CARES process into two phases. The first phase consisted of a pilot project in VISN 12, the Great Lakes Health Care System. Phase II extended the initiative to the remaining 20 VISNs, and was initiated on June 6, 2002.[5] The planning model for Phase II was implemented and the process well underway when the Commission conducted its first meeting in February 2003. The Commission's

[5] Capital Asset Realignment for Enhanced Services (CARES), *CARES Guidebook – Phase* II, (Second Edition, June 2002), Chapter 1, pages 1-2.

charter is to consider the proposals submitted by the Under Secretary for Health (USH) regarding the realignment and allocation of capital assets to meet veteran health care needs over the next 20 years.[6] Specifically, the Commission was charged with considering these proposals along with data and analyses in support of them.[7] In its review of the DNCP, and subsequent data provided by the National CARES Planning Office (NCPO), the Commission noted the scarcity of consistent, reliable data, a lack of uniform supporting documentation, and an absence of a standardized analysis format to assist Commissioners in making specific recommendations.

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In addition, as is more fully explained in Chapter 3 of this report, the process omitted long-term care, including long-term mental health care, from its projections. These services also must be taken into account prior to undertaking any significant capital investments or any actions that would impact the delivery of long-term care, including long-term mental health care.

Planning Model

In conducting its analysis of the DNCP, the Commission first reviewed the enrollment projections developed as the basis for the CARES planning process. The Commission sought expert advice from Robert E. Burke, PhD, and Peter Shin, PhD, of the George Washington University School of Public Health and Health Services, and Thomas E. Mannle, Jr., of Pilot Consulting Services, on the accuracy and reliability of these projections over the 20-year planning period.

The CARES model is the foundation for projections and proposed solutions expressed in the DNCP. The Commission determined that the CARES model provided a reasonable analytical approach for estimating VA enrollment, utilization, and expenditures.[8] The Commission deferred final acceptance of the projections, however, until assured that a revised model would include necessary modifications, including a sensitivity analysis that would establish a "lower-bound" estimate of enrollment, and use of data on enrollment rates based on a 30-month period rather than the 13 months used in the model.[9]

[6] Appendix B, *CARES Commission Charter,* Dated 12/16/02.
[7] Appendix B, *CARES Commission Charter,* Dated 12/16/02.
[8] See Burke, R.E., Mannle T.E., Shin, P. *Independent Assessment of the VA Enrollment, Utilization, and Cost Projection Model.* Final Report: May 30, 2003.
[9] CARES Commission meeting, August 7, 2003. *Available at www.carescommission.va.gov/MeetingMinutes.asp.*

This lower-bound sensitivity analysis was not conducted prior to the end of the Commission's work, and a later version of the model relied on a 12-month timeframe instead of the recommended 30 months of data. As a result, the Commission strongly recommends that initiatives in the DNCP requiring significant capital investment not be approved without a rigorous re-examination of the sustainable enrollment base justifying each investment.

Supporting Data

CARES is built on a sound foundation of comprehensive data. The Commission determined that these data, developed in the initial steps of CARES, show that VHA conducted an extensive and detailed system-wide assessment of the critical components that determine future need for capital and services. This assessment included:

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- *Enrollment* – CARES utilized enrollment forecasts by priority group, based upon the Secretary's enrollment decisions and the President's budget request.
- *Utilization* – CARES developed the expected utilization of enrollees for bed days of care and outpatient visits for all priority groups by age and gender and the specific needs of the SCI and Blind Rehabilitation programs. Further, CARES prompted VISN decisions on managing utilization changes from a range of alternatives including: new construction, renovation, leases, and contracts.
- *Access* – CARES determined driving times to primary outpatient and acute inpatient care based upon the current locations of VA sites of care to gauge the percentage and number of veterans who are within travel time guidelines.
- *Physical Plant* – CARES developed and used assessments of the current condition and functionality of all space that provides and supports the delivery of health care services. A comprehensive evaluation was conducted to determine the amount of space that did not meet current standards and that should be improved.
- *Vacant Space* – CARES brought about the evaluation of all vacant space, including determination of potential use in meeting future expected utilization and possible disposition alternatives including: lease, demolition, and other divestiture measures.
- *Realignments* – CARES facilitated a systematic assessment of the potential for realignment of services and campuses.
- *Collaborations* – CARES identified opportunities to jointly address VBA, NCA, and DoD needs for space.[10]

[10] DNCP, *Chapter 1: CARES*, page 3.

These comprehensive data enabled the VISNs and NCPO to develop sound planning initiatives (gaps between current utilization and projected demand). These data-supported planning initiatives in turn provided the basis for the subsequent VISN market plans (proposed solutions) and ultimately the DNCP.

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Upon receipt of the DNCP, the Commission undertook a review of the data and analysis supporting the plan. As discussed earlier, the Commission noted the scarcity of verifiable documentation to develop sound recommendations. Missing information included: 1) specific cost data for new initiatives; 2) specific timelines for implementation of the DNCP proposals; and 3) potential savings generated through national realignment of resources. There is neither reference to the correlation of the data to individual recommendations, nor reference to strategic factors influencing the decision process. In requesting additional information from the NCPO, the Commission learned that the decision process was not sufficiently documented, and that proposals put forth by the individual VISNs apparently were generally accepted with little coordinated review or analysis.

The Commission also identified significant variances in how individual VISNs submitted data during the planning process. The Commission understands, and the NCPO acknowledges, that standard industry tools to assess the reliability and validity of data were not applied to the individual VISN submissions, leading to inconsistencies. The DNCP does not include documentation of the variances in data or how they were addressed in the decision-making process.

Additionally, for each recommendation, the DNCP does not reference the rationale for choosing a specific solution as compared to alternatives. Such rationale should have included an analysis of the potential options and a comprehensive review of the cost/benefit analysis of each, including impact on access, quality of care, and the community. This deficiency is particularly true for the campus realignment and consolidation proposals, where data to conduct this type of analysis were gathered several months after the publication of the DNCP. Moreover, the failure to maintain sufficient records to fully identify rationale presented other issues for the Commission. Nevertheless the Commission is satisfied that the foundational data collected early in the CARES process was sound, and enabled the Commission to move forward with its review of the DNCP, notwithstanding the concerns raised with its use in developing the DNCP as delineated above.

Commission Approach

In light of the scarcity of consistently reliable data to support the recommendations in the DNCP, the Commission consolidated and analyzed all information gathered from site visits, public hearings, public meetings, and data generated by the NCPO. Based on available information and insight derived from its experience in the VISNs, the Commission used its best collective judgment, applying its diverse expertise in making decisions related to the future of VA infrastructure. The Commission developed specific factors and applied them to each DNCP proposal to assess the proposal's reasonableness. These factors are:

- Impact on veterans' access to care
- Impact on health care quality
- Veterans and stakeholder views
- Impact on the community
- Impact on VA missions and goals
- Cost to government

The CARES process advances VA's efforts to ensure the continued availability of quality health care for the veterans it serves. An appropriate process for self-assessment and renewal is vital for any quality organization in a dynamic environment such as health care.

In applying these factors, the Commission evaluated each proposed initiative using available data and written analyses submitted by individual VISNs and by the USH. The Commission's recommendations, provided in subsequent sections of this report, are based on this evaluation and the incorporation of the knowledge gained through the Commission's study of the system.

The Future

The CARES process advances VA's efforts to ensure the continued availability of quality health care for the veterans it serves. An appropriate process for self-assessment and renewal is vital for any quality organization in a dynamic environment such as health care. If this process is to realize its potential, VA must continually refine the CARES model and fully integrate it with strategic planning. Moreover, VA cannot operate in a vacuum; veterans, Congress, stakeholders, and the greater health care community influence the utilization trends, care modalities, costs, and accepted protocols of health care delivery.

The Commission supports VA plans to make the CARES process an integral and ongoing component of its approach to planning, and executing its mission. The continuing need for an integrated planning and allocation process is even more important as collaboration with other government agencies, such as DoD, gains momentum. Finally, the Commission recommends the Secretary establish an independent advisory body, with appropriate charter and authority, to monitor and advise the Secretary on the ongoing integration of CARES into VA's strategic planning process.